MISSOURI DEPARTMENT OF MENTAL HEALTH

LEGISLATOR BRIEFING

January 2021

Mental Health Highlights and Issues

FEATURING COVID RESPONSE INNOVATION

I. DMH: COVID-19 Response

The Department of Mental Health (DMH) is a safety net, human services organization delivering programs and services to some of Missouri's most vulnerable citizens. Our staff is innovative, collaborative and mission driven, but, above all, committed to excellence in public service. This document provides an overview of DMH structure, program highlights and critical issues, and how we handle constituent issues for our elected officials.

Since 2020 was an extraordinary year, this briefing begins with the DMH response to the global pandemic.

The Department of Health and Senior Services (DHSS) is the lead on COVID-19 due to their public health mission, but DMH is also at the forefront of Missouri's pandemic response. An established Office of Disaster Services and Continuity of Operations Plan (COOP) anchored DMH efforts. When efforts shifted from monitoring to statewide response, DMH mobilized central office and facility leadership/expertise into a COVID-19 Team to participate in cross-departmental briefings and the statewide COVID-19 Fusion Cell (CFC), which is a multi-agency policy team collaborating across Missouri state government to address key concerns caused by the virus.

> *"I am proud and humbled by the efforts and dedication of DMH employees throughout our system. When faced with uncertainty, our teams persevered.*
>
> *"Our clients and colleagues are more like family than 'work' to us. I want our elected officials to know that DMH has the best staff in state government."*
>
> DMH Director Mark Stringer

Keeping our staff and clients healthy and safe is always a priority but has been a unique challenge during the ever-changing pandemic response. Sadly, as of this writing, DMH has lost 11 clients and five staff members to the virus, and more than 2,100 colleagues and clients have contracted COVID-19. Learn more about the direct impact on our system via this link, which is regularly updated. Details on our overall efforts can be found here. Learn more about Missouri's COVID-19 response at https://showmestrong.mo.gov/.

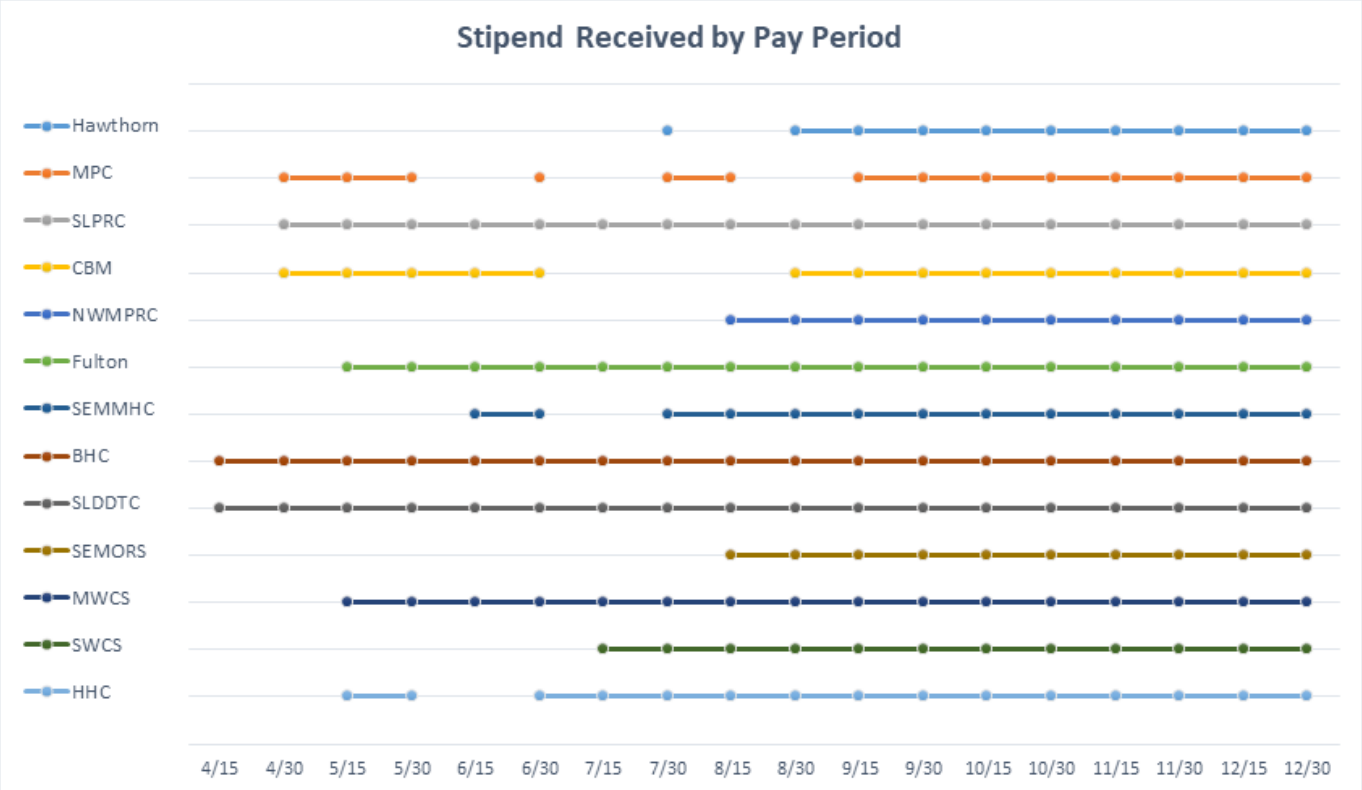
DMH COVID-19 efforts continue and include:

Pandemic Hazardous Stipend Pay

Pandemic Hazardous Stipend Pay has been a critical component to DMH's successful fight against COVID-19. Through the December 31, 2020 pay period, 76,753 paychecks of DMH facility employees have reflected the $250 stipend. Since our first staff COVID-19 positive on March 14, DMH has reported positive staff or residents in every DMH facility. Our first positive resident was identified on March 26. Anxiety was (and is) high among staff and residents. For example, on March 27—before the stipend was initiated—31 of 64 scheduled

staff did not show up for our 2nd shift (48% of staff scheduled) at a facility with positive staff and residents. Another facility with a positive resident experienced 40 call-ins on April 1st.

The hazardous pay stipend went into effect for the April 1st pay period and was announced shortly thereafter. Immediately, call-ins for that facility decreased to 9 on April 5th. With hazardous stipend pay, facilities decreased implementation of minimum staffing protocols (e.g., not allowing breaks, holding staff over their shifts, and staffing at less than desirable staffing levels). DMH also gained strong employee cooperation with COVID-19 prevention efforts such as high compliance with COVID-19 testing, mask wearing, social distancing, and employee screening. We believe the stipend pay has helped DMH convey the seriousness of COVID-19 ***and*** the State's concern for our workforce in the 13 facilities supporting vulnerable Missourians. Through the 18 pay periods that hazardous pay has been available, DMH has had at least one facility access hazard pay stipend for every pay period. The chart below shows the frequency by facility that the stipend has been accessed. As a result, DMH has been able to decrease COVID-19 among our residents by 97%, from a high of 34 positive residents in April to 1 positive resident in August. During this same timeframe, COVID-19 among DMH staff has increased by nearly 92% (46 in April and 88 in August)—not unexpected given community transmission and our efforts to keep COVID-19 out of the facilities.



Personal Protective Equipment (PPE)

Providing staff with protective gear is critical in a pandemic. PPE was difficult to secure early in the virus response due to global supply and demand. DMH worked with the State Emergency Management Agency (SEMA) to obtain large orders for our system and other congregate care agencies. DMH selected Fulton State Hospital (FSH) for centralized PPE storage and distribution. FSH staff monitor PPE supplies, fill orders, and coordinate the distribution of items such as N95 masks, gloves, hand sanitizer and gowns. Facilities typically

request three weeks of PPE per order; orders vary based upon on the positivity rate in the state/county/city, positive cases in the facilities, and PPE available based upon the supply chain. For example, N95 masks and large gloves have been difficult to secure.

Show Me Hope Crisis Counseling

In response to the COVID-19 pandemic, the *Show Me Hope* Crisis Counseling Program (CCP) received funding for psychological services to build hope and resiliency in Missourians. The Federal Emergency Management Agency (FEMA) awarded an $8.9 million CCP Regular Services Program (RSP) grant to DMH for service delivery and outreach services through 24 participating mental health agencies. The RSP launched September 15 and is operated by the Office of Disaster Services with guidance from our federal partners, FEMA and the Substance Abuse Mental Health Services Administration (SAMHSA). These funds build upon CCP programming initiated in June with prior FEMA funds and in collaboration with these same Federal partners.

Show Me Hope crisis counselors connect Missourians statewide with local mental health resources. The crisis counselors teach coping skills and stress management, and make referrals to services that are free and confidential to anyone experiencing anxiety or other mental health concerns due to the pandemic. Most services are provided virtually but counselors are also available in the community, at COVID testing sites, and other public events when they can adhere to CDC guidelines, https://www.cdc.gov/coronavirus/2019-ncov/index.html. Counselors provide education and outreach to school systems, businesses, communities, and special populations such as seniors, children/youth, immigrants, veterans, the unhoused and any Missourian needing emotional support during these historic times.

Any individual experiencing stress or emotional strain because of the pandemic may call or text the Disaster Distress Helpline 24 hours a day, seven days a week at 1-800-985-5990. A licensed professional is available to discuss concerns and link to the local Show-Me Hope program.

MO Show Me Hope Crisis Counseling Program:
Website: https://www.moshowmehope.org/
Facebook: https://www.facebook.com/Missouri-Show-Me-Hope-Crisis-Counseling-Program-110293060677590/
Twitter: https://twitter.com/MOShowMeHope

StationMD

The Division of Developmental Disabilities partnered with StationMD to provide telemedicine services at no cost to individuals with Intellectual and Developmental Disabilities (I/DD) receiving Home and Community Based Waiver services. StationMD offers immediate virtual access to high-quality emergency medicine physicians specifically trained in the care of people with I/DD. The service is available 24/7 for individuals, families or staff and includes immediate evaluations, video-assisted examinations, treatment plans, and discussion and coordination with individuals and/or caregivers. This telemedicine service allows individuals to be served at home and has decreased demand and stress on urgent and emergency care.

Suicide Prevention

According to the June 2020 CDC report, 40% of adults reported struggling with mental health or substance use issues, and 11% seriously considered suicide. “The public health response to the COVID-19 pandemic should increase intervention and prevention efforts.” DMH has been proactive in addressing mental health promotion and suicide prevention during the pandemic, including:

- Implementing $2.5 million in Federal grants including:
  - Missouri’s *COVID-19 Emergency Response for Suicide Prevention* grant to reduce the overall number of suicides through integration of suicide prevention in healthcare systems, particularly in emergency rooms. $800,000
  - The *Zero Suicide in Health Systems* grant, addressing suicide prevention for adults in healthcare systems in St. Louis and Kansas City. $725,000
  - The *Show Me Zero Youth Suicide* grant, providing mental health liaisons and clinical care for youth in schools and emergency rooms. $736,000
  - The 9-8-8 State Planning Grant preparing Missouri for the National Suicide Prevention Lifeline’s 988 Dialing Code.(3 digit connection to mental health nationwide; 988 launches July 2022) $260,000

- The Missouri Suicide Prevention Network hired two full-time staff to help guide implementation of the state suicide prevention plan.
  - Created the Missouri Suicide Prevention Advocacy Network (Missouri SPAN) to raise awareness that suicide is a public health issue and to gain broad-based support for suicide prevention advancement, www.mospn.org/missourispan
  - Created three COVID-related subcommittees: 1) Communications, 2) Post-vention/Rapid Response (created rapid response protocols and suicide loss resources), and 3) Enhanced Data Collection and Reporting.
  - Updated and promoted an online statewide suicide training resource: https://www.moasklistenrefer.org/main

- Extending and expanding suicide prevention campaigns to reach all Missourians, through CARES ACT funding. $620,000
  - Created virtual social media toolkits for teen suicide prevention https://thesocialpresskit.com/teen-crisis and adult suicide prevention https://thesocialpresskit.com/help-him-stay#
  - Partnered with Department of Natural Resources (DNR) to place signs in all state parks.
  - Partnered with Department of Elementary and Secondary Education (DESE) to place signs and other resources in all schools.
  - Currently partnering with Prevention Resource Centers and other community agencies (including county health departments) to target high risk counties.

- Providing *Signs of Suicide* training to schools.

- Collaborated with University of Missouri's Telehealth Network and Show Me ECHO to launch a new Suicide Prevention in Health Care ECHO. It will be held the first and third Friday of each month from noon to 1:00 p.m. An interdisciplinary team of mental health specialists from across the state will share information about best practices, plans and procedures for preventing suicide. Primary care and emergency medicine providers, school officials, law enforcement personnel and other professionals who interact with the mental health community are encouraged to participate. Register at: https://showmeecho.org/clinics/suicide-prevention-in-health-care/.

- Offering free suicide prevention and mental health trainings to the general public, including Question Persuade Refer, Mental Health First Aid, and a series of suicide prevention webinars.

- Training healthcare providers in suicide prevention and intervention.
  - Hosted another Zero Suicide Academy in August 2020 with 14 organizations participating.
  - Partnered with the Missouri Hospital Association to bring *Collaborative Assessment and Management of Suicidality* (CAMS) training to hospital systems statewide.

- Created a workgroup to lead implementation of the national PREVENTS pledge and coordinate statewide suicide prevention best practices for the military-connected community.

- Providing law enforcement pocket-sized brochures and other materials that include contact information for the DMH crisis care system.

- Collaborating with Department of Corrections (DOC) to provide support/resources for employees at risk for suicide.

- Responding to daily requests for suicide prevention information and resources for schools, other agencies, media, etc.

Testing

Identifying the virus early in congregate care settings can save lives. DMH implemented robust testing for all staff and residents in the Spring. This includes routine surveillance testing, outbreak testing, and courtesy testing for staff who believe they were exposed within or outside of the facility.

Mandatory testing for DMH facilities began May 2020. Each DMH facility has the capacity to conduct PCR testing and rapid antigen testing. Five facilities are using saliva-based testing in collaboration with researchers at Washington University in St. Louis. In addition to testing our staff and clients, DMH leverages sewer-shed testing at seven DMH facilities to monitor COVID levels among our facility population. DMH currently tests 10-15% of facility staff and residents

each week. Testing levels vary based upon community transmission rates and current outbreaks within facilities.

Mandatory surveillance testing for non-facility DMH staff began late August/early September 2020. Approximately 10% of DMH non-facility staff are tested once per week. Staff may request courtesy testing if they believe they have been exposed in the community, and we conduct outbreak testing for any individuals that may have been a direct contact in the work setting. To date, DMH has facilitated more than 167,000 COVID-19 tests for staff and residents.

Vaccinations

DMH vaccinations began in late December 2020, and first recipients were healthcare staff working directly with patients/clients.

Following CDC guidance, the vaccine will be distributed in phases. DMH hospitals and congregate care facilities are part of phase 1A.

Phase1A: Healthcare Workers *(patient facing)* **and** Long-term Care Facility Residents/Staff

Phase1B: First Responders **and** Essential Workers **and** High Risk Populations (*18-64 with I/DD and underlying conditions and people over 65*)

Phase 2: Populations at Increased Risk *(Prisoners, Homeless, etc.)*

Phase 3: All Missouri Residents

Review Missouri's state vaccination plan at https://covidvaccine.mo.gov/.

II. Department of Mental Health Overview

The Department of Mental Health (DMH) annually serves more than 170,000 Missourians with mental illness, developmental disabilities, and substance use disorders. It is a safety net for the state's most vulnerable citizens and their families. Our primary populations include:

- **Adults with serious mental illness and children with severe emotional disorders**
- **People with developmental disabilities**
- **People with severe substance use disorders (SUDs).**

Community-based contract providers serve more than 95% of these individuals. Approximately 60% are Medicaid eligible. (With Medicaid expansion, this percentage will change substantially.)

MENTAL HEALTH COMMISSION

The seven-member Mental Health Commission appoints the DMH director with Senate confirmation. Commissioners serve as the principal policy advisers to the department. The Governor, with Senate confirmation, appoints commissioners to terms of varying lengths.

Commission member positions must include individuals who represent Missourians with mental illness, developmental disabilities, and substance use disorders, and who have expertise in general business matters (630.010 RSMO).

DMH MISSION (RSMO Chapter 630.020)

Prevention: Reduce the prevalence of mental disorders, developmental disabilities, and substance use disorders.

Treatment and Habilitation: Operate, fund, and license or certify modern treatment and habilitation programs provided in the least restrictive environment.

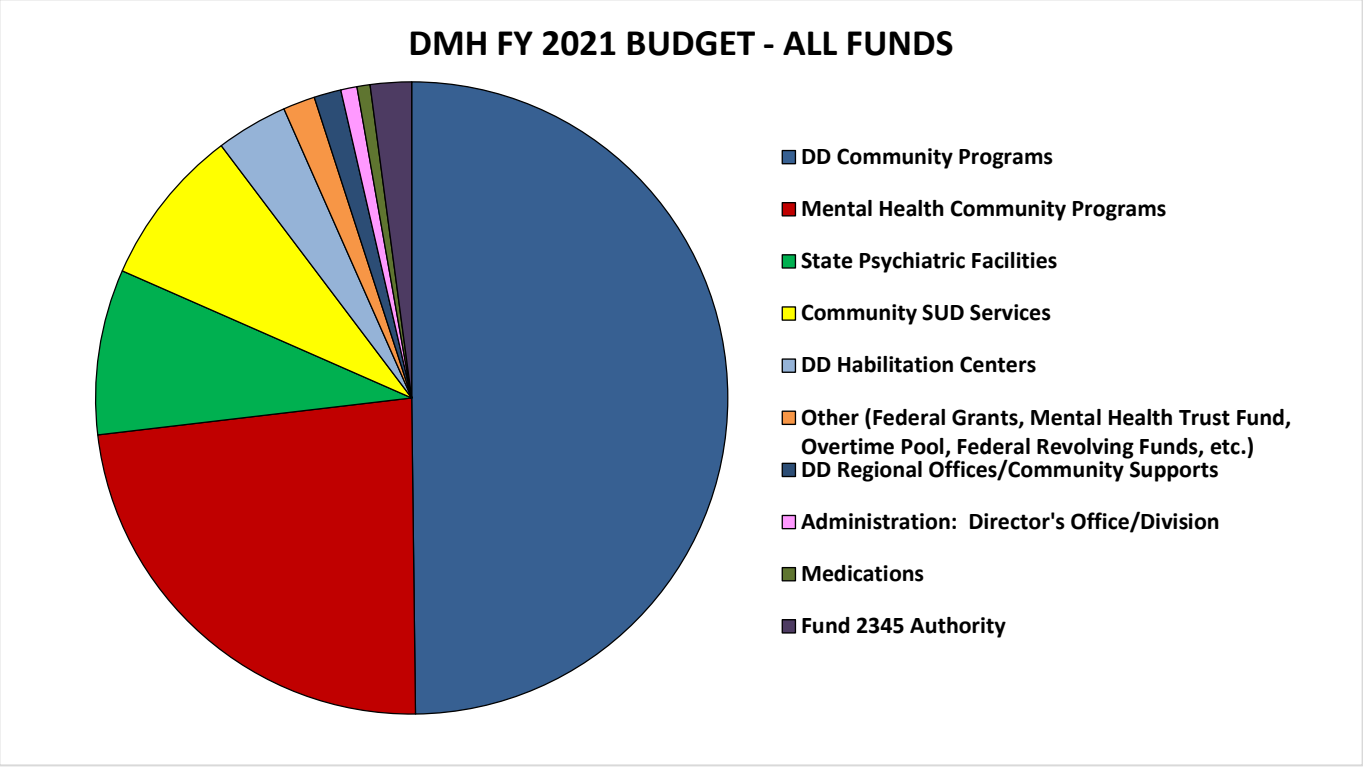
Improve Public Understanding: Improve public understanding and attitudes toward individuals with mental illness, developmental disabilities, and substance use disorders.

DMH DIVISIONS

- **Division of Behavioral Health (DBH) –** RSMO Ch. 631 and RSMO Ch. 632 *(formerly the Divisions of Alcohol and Drug Abuse and Comprehensive Psychiatric Services)*
- **Division of Developmental Disabilities (DD) –** RSMO Ch. 633
- **Division of Administrative Services**

III. FY 2021 DMH Budget by Program Category

Budget Category	Amount	% Total	FTE
DD Community Programs	$1.226 billion	49.81%	25 FTE
Mental Health Community Programs	$574 million	23.33%	30 FTE
State Psychiatric Facilities	$208 million	8.45%	3,773 FTE
Community SUD Services	$200 million	8.12%	29 FTE
DD Habilitation Centers	$90 million	3.67%	2,443 FTE
Other (Federal Grants, Mental Health Trust Fund, Overtime Pool, Federal Revolving Funds, etc.)	$41 million	1.63%	10 FTE
DD Regional Offices/Community Supports	$34 million	1.38%	691 FTE
Administration: Director's Office/Divisions	$20 million	0.83%	221 FTE
Medications	$16.5 million	0.67%	0 FTE
Fund 2345 Authority	$52 million	2.10%	13 FTE
TOTALS	$2.4615 billion	100.0%	7,235 FTE



- In FY 2021, the DMH budget was approximately 7% of the state's total operating budget.
- DMH generates $303 million per year in reimbursements from Medicaid, Medicare, disproportionate share (DSH) payments and other third party payer sources.
- Approximately 63% of all DMH GR funding is used as state match for services funded through the Medicaid program.

DMH CONTRACTED SERVICES

- DMH contracts with more than 1,400 provider agencies employing 30,000 people statewide.
- More than 95% of the Department of Mental Health's 170,000 consumers receive their services through contracted community-based provider agencies.

STATE OPERATED SERVICES

BEHAVIORAL HEALTH	DEVELOPMENTAL DISABILITIES
5 hospitals for adults 1 hospital for children	4 state-operated habilitation centers 2 community support agencies 1 crisis community support agency 5 regional offices, 6 satellite offices

State operated services in the Behavioral Health division include the Sex Offender Rehabilitation and Treatment Services (SORTS) program for sexually violent predators. The SORTS program is located at Southeast Missouri Mental Health Center in Farmington and at Fulton State Hospital.

IV. DMH Program Highlights and Critical Issues

PROGRAM HIGHLIGHTS	CRITICAL ISSUES
• Avoiding Crisis for BH/DD Individuals • Medication Assisted Treatment for Substance Use Disorders • Improving Community Treatment Success • Certified Community Behavioral Health Organizations (CCBHO) Prospective Payment System Demonstration Project • Missouri Model of Crisis Intervention • Recovery Support Services	• Preventing the DD Wait List • Critical Clinical/Direct Support Professionals Staffing Shortages • DD Community Provider Rate Corrective Action Plan • Employment • Opioid Crisis • Provider Rate Inequities • State Inpatient Facility Capacity • Uninsured Individuals Seeking Services

PROGRAM HIGHLIGHT: Avoiding Crisis for BH/DD Individuals

Every year people with both a behavioral health disorder and a developmental disability are referred to DMH. Some of these individuals' needs cannot be met by the current community service delivery system funded by the Department. Leaders of the Divisions of Behavioral Health (DBH) and Developmental Disabilities (DD) are working together with providers to build systems ensuring that individuals served by both Divisions receive effective services. These efforts include:

- Department leadership prioritizing effective services by establishing cross agency standards of best practice;
- The Missouri Alliance for Dual Diagnosis (MOADD) is a collaborative effort between state-wide clinicians, private and contracted providers, and DMH staff to build provider capacity and promote best practices for individuals with a co-occurring diagnosis (intellectual/developmental disability and behavioral health). To efficiently connect with a variety of professionals supporting this population, MOADD is utilizing the Extension for Community Healthcare Outcomes (ECHO) model which launches March 2021. The MOADD ECHO "tele-mentors" those supporting and treating individuals with a co-occurring diagnosis on best practice approaches. The MOADD App for smart phones defines best practices for clinicians supporting individuals with a dual diagnosis and launches in 2021, too.
- Chairing the MOADD is a group of dedicated staff performing risk assessment, identifying systemic interventions, and reducing crisis events;

- Training and coaching for contracted agencies to prevent crisis events;
- Pilot implementation of the Department's Co-Occurring Protocol, coordinating services across Divisions;
- Increased enrollment of DBH providers into the DD system;
- Accessing the established, successful DBH crisis system.

Additional funding will be necessary to provide the full continuum of care for these individuals. The additional funding is needed to:

- Build capacity for implementation of preventative strategies;
- Expand implementation of best practices by qualified providers;
- Develop an intensive behavioral respite for adults and children offering options other than the emergency room or jail;
- Create an intensive behavioral residential service for adults and children that are unsuccessful living in the community;
- Expanded coordination of services provided by the two Divisions.

PROGRAM HIGHLIGHT: Medication Assisted Treatment for Substance Use Disorders

Substance use disorders (SUD) are chronic medical conditions and should be managed like diabetes and heart disease. Evidence-based medications can treat opioid and alcohol use disorders effectively. These medications drastically reduce cravings and allow the individual to focus efforts on non-medical clinical treatment services. Individuals using medications for SUD can obtain/sustain employment, attain stable housing, reduce criminal activity, and rebuild relationships. In state-funded programs, the number of individuals receiving such medications for Opioid Use Disorder (OUD) or Alcohol Use Disorder (AUD) increased from 7,587 in FY 2018 to 9,014 in FY 2020 which shows a 19% increase over that time period.

Between FY18 and FY20, DMH documented these impacts of addiction medications:

- The length of service for individuals receiving addiction medications for OUD or AUD increased from an average of 138 days in FY 2017 to an average of 188 days in FY 2020. Research indicates that most individuals need at least three months of treatment to stop or reduce their use and that the best outcomes occur with longer durations of treatment.
- While the percentage of individuals using medication for an OUD or AUD has increased from 24% in FY 2017 to 36% in FY 2020, the percentage of individuals receiving detoxification or residential services has decreased from 32% in FY 2017 to 22% in FY 2020. Individuals served with addiction medications experience less disruption to employment and familial relationships while receiving treatment.

For individuals with Medicaid who were diagnosed with an OUD or AUD in FY 2019, the following data emerged:

- For the last three years of service follow-up, a person who received medications in a given year **visited the emergency department during the next fiscal year at a much lower rate** than those who did not receive addiction medications. For those served in FY 2019, the average number of emergency department visits in FY 2020 was .86 for those who received medication assisted treatment and 1.92 for those who did not receive medication assisted treatment.

- For the last three years of service follow-up, a person who received medications in a given year had **fewer hospital stays, on average,** during the next fiscal year than those who did not receive addiction medications. For those served in FY 2019, the average number of hospitalizations in FY 2020 was .63 for those who received medication assisted treatment and 1.60 for those who did not receive medication assisted treatment.

- The **average total Medicaid cost for a person with OUD or AUD is much less** in the year following service for those individuals that receive addiction medications than it is for those that do not receive these medications. For those served in FY 2019, the average total Medicaid cost in FY 2020 was $7,158 for those who received medication assisted treatment and $14,536 for those who did not receive medication assisted treatment.

Long-term treatment with FDA-approved OUD medications (*predominantly buprenorphine and methadone*) combined with psychosocial supports (*i.e. counseling and recovery supports*) are the most effective in managing this chronic illness. However, physicians receive insufficient training on SUD treatment protocols in medical school, and federal restrictions are significant. Some restrictions have been temporarily lifted due to COVID-19. Buprenorphine can only be prescribed by specially trained physicians (*known as "waivered physicians"*) and their caseload is limited to 30 patients in year one and up to 275 patients in year two. Advanced practice nurses (APRNs) are federally approved to prescribe buprenorphine, but in Missouri APRNs are restricted to a 30-day prescription and required to be in a collaborative relationship with a waivered physician. Methadone has a long history of success, yet can only be prescribed within specialty opioid treatment programs (OTPs), which further limits access. However, effective October 1, 2020, DMH added two new Comprehensive Substance Treatment and Rehabilitation (CSTAR) organizations that operate 11 clinics across Missouri, to the network of providers, thereby increasing access to methadone for more citizens. Note: there are not similar requirements to use the medications approved for the treatment of AUD.

Unlike medications for other chronic illnesses, medications for SUDs have been adopted slowly, primarily because of the lack of education for prescribers and the general public. Despite the resistance in some parts of the country to using these medications, Missouri is nationally recognized as a leader in employing Medication Assisted Treatment (MAT) for SUDs. For many individuals, these medications literally have been lifesavers. However, as with all services for individuals with SUDs, the demand for treatment interventions far exceeds the available

resources. For more information visit https://dmh.mo.gov/alcohol-drug/medication-assisted-treatment and http://www.missouriopioidstr.org/.

PROGRAM HIGHLIGHT: Improving Community Treatment Success

In 2017, Missouri leaders requested and received support from the U.S. Department of Justice, Bureau of Justice Assistance (BJA), to employ a Justice Reinvestment Initiative (JRI) approach to study the state's criminal justice system with technical assistance from the Council of State Governments (CSG). Missouri passed JRI legislation in 2018, and an executive-level JRI Taskforce sets policy and oversees the project. Three key findings emerged from a comprehensive data analysis of state agencies: 1) there was an increase of violent crime, 2) there were high recidivism rates among individuals on probation or parole, and 3) there was insufficient behavioral health treatment for individuals under supervision.

Department of Corrections (DOC) and DMH collaborated to implement the JRI Treatment Pilot (JRITP), which established a community behavioral health program to provide comprehensive community-based services for individuals with substance use and co-occurring (substance use and mental health) disorders who are under the supervision of DOC and considered high risk for reoffending. The pilot launched September 2018 in Boone, Buchanan and Butler counties based on high recidivism and violent crime rates. Following their success, the pilot expanded into Greene and Polk counties in December 2019. JRITP progressed beyond the pilot stage, prompting a name change in 2020, to Improving Community Treatment Success (ICTS) for justice-involved clients. The program further expanded to Cole, Pettis, Phelps, Pulaski, and St. Francois counties. The goal of ICTS is to provide effective, individualized treatment services that address criminogenic needs and risk factors in order to lower crime, decrease system costs, and contribute to a safer, healthier Missouri. As of November 24, 2020, over 700 individuals have been served by the ICTS program.

PROGRAM HIGHLIGHT: Certified Community Behavioral Health Organizations Prospective Payment System Demonstration Project

Certified Community Behavioral Health Organizations (CCBHOs) developed from the Excellence in Mental Health Act (*co-sponsored by Senator Roy Blunt*) which supported a demonstration program to create national standards and allow for cost-related reimbursement. CCBHOs provide the most comprehensive array of integrated, evidence-based behavioral health services for individuals with serious mental illnesses and substance use disorders. Agencies designated by the Division of Behavioral Health (DBH) as a CCBHO are part of the demonstration project that moves select Missouri providers from a fee-for-service system to a Prospective Payment System (PPS). The demonstration award provides an enhanced federal match during the demonstration period for the CCBHOs and is similar to the Federally Qualified Health Center (FQHC) model of service and reimbursement. The demonstration implementation project was awarded in December 2016 to Missouri, one of only eight states to receive an award. Missouri's demonstration began July 1, 2017, with 15 Community Mental Health Centers participating. Initial outcomes indicate that CCBHOs increase the number of individuals served,

significantly decrease wait times for appointments, and provide opportunities for service delivery in venues that did not previously exist (e.g., criminal justice agencies and schools).

The Department is actively engaged in sustainability planning, looking towards the transformation of more Community Mental Health Centers into CCBHOs, as well as changing the reimbursement model for other DMH behavioral health providers to a PPS. As of July 1, 2019, the Department has an approved state plan amendment for CCBHOs through the Centers for Medicaid and Medicare (CMS). As of 2020, all CCBHOs were officially certified under this state plan amendment. Additionally, the demonstration has been extended through September 30, 2023. For more information visit https://dmh.mo.gov/certified-community-behavioral-health.

PROGRAM HIGHLIGHT: Missouri Model of Crisis Intervention

The Missouri Model of Crisis Intervention is a partnership between law enforcement, the Department of Mental Health, the Missouri Coalition for Community Behavioral Healthcare and community stakeholders. It addresses the needs of individuals in crisis with a focus on the right interventions provided in the right way at the right time to improve outcomes and efficiently manage resources. The Missouri Model will become the national standard for assisting individuals with mental illness and substance use disorders who are in crisis. Launched in 2013, the components of the Missouri Model are:

- **Crisis Intervention Team (CIT) Training**
  - More than 10,000 law enforcement personnel have been trained on how to approach and assist individuals who are experiencing a crisis due to mental illness, substance use or developmental disability. Currently, CIT Councils cover 100 counties in Missouri. The State CIT Council recently developed the Missouri Model for CIT Training.
- **Community Mental Health Liaisons (CMHLs)**
  - Statewide, 31 Liaisons based at community mental health centers work with local law enforcement and court personnel to connect people experiencing behavioral health crises to treatment and community services.
  - CMHLs have referred over 74,700 individuals in crisis for services. CMHLs have provided more than 920 trainings on behavioral health topics, with over 13,600 officers trained. These trainings are provided at no cost to law enforcement and are Peace Officer Standards and Training (POST) certified.
- **Emergency Room Enhancement (ERE) Projects**
  - In 2020, the ERE program was available in 13 service regions covering 82 of the 114 Missouri counties accounting for 87% of Missouri's population. This year, ERE will be adding a 14th service region providing wrap around care for more Missourians.
  - To date, more than 11,248 individuals received services after being engaged in ERE. The majority of participants identified at least one of the following: mental health

concern (95%), substance use concern (80%), or physical health concern (76%). Further, a significant portion of participants (78%) present with both psychiatric and substance use concerns. During the 2020 fiscal year, a total of 2,029 participants engaged in services.

  - In the 2020 fiscal year, individuals who remained engaged in the ERE program for six months showed a 74% reduction in ER visits, 74% reduction in hospitalizations, 69% reduction in law enforcement contacts, 60% reduction in unemployment, and a 76% reduction in homelessness.

- **Mental Health First Aid (MHFA) Training**

  - Over 53,000 Missourians have been trained in MHFA, a national program that teaches participants about the signs and symptoms of specific mental illnesses like anxiety, depression, schizophrenia, bipolar disorder, and addiction.

PROGRAM HIGHLIGHT: Recovery Support Services

Recovery Support Services (RSS) offer care coordination, recovery coaching, spiritual counseling, group support, recovery housing and transportation before, during, after, and in coordination with other substance use disorder service providers. These services are offered in a multitude of settings including community, faith-based, and peer recovery organizations. Recovery support programs are person-centered and self-directed allowing individual choice of provider. In FY2020, RSS providers served over 2,300 individuals.

RSS Outcomes at six months:

- 84% are abstinent
- 63% employed
- 98% no new legal problems
- 90% have stable housing
- Average cost of RSS services per consumer is $687.34

There are currently 1,207 National Alliance for Recovery Residence accredited Recovery Housing beds providing safe, peer supported housing in Missouri's 120 active houses.

CRITICAL ISSUE: Preventing the DD Waitlist

The FY 2020 budget re-introduced and the FY 2021 budget continues the Division of Developmental Disabilities (DD) waitlist for services. Prior to July 1, 2019, the Division had not operated with a waitlist since FY 2014. In FY 2021, the Division requested $26.1 million general revenue to serve an additional 2,823 individuals who present for services and who are Medicaid eligible. The Governor Recommended budget included $30.3M for 1,302 individuals with disabilities to access both residential and in-home services The TAFP budget only included $5.2M to continue services for those served in FY 2020, as well as $7.7M for eliminating the waitlist for services. On October 7, 2020, Governor Parson released from expenditure restriction

$3.8 Million General Revenue to start addressing the waitlist for developmental disability waiver services. On January 6, 2021, Governor Parson released an additional $3.9 million general revenue. This was the second and final release of the $7.7 million general revenue that had been placed in restriction in July 2020. With this release the Division continues to address the waitlist for Developmental Disability waiver services. For FY21, these dollars move:

- 194 individuals off the Residential Services Waitlist (Residential services are the most costly services funded by the division, and historically 23 people per month have been added.),
- 540 individuals off the In Home Waitlist, and
- Individuals off the Partnership for Hope Waitlist as needed

As of January 1, 2021:

- 174 individuals were on the residential waitlist,
- 571 individuals were on the in-home waitlist, and
- 191 were on the Partnership for Hope Waitlist.

CRITICAL ISSUE: Critical Clinical/Direct Support Professionals Staffing Shortages

Missouri state-operated facilities and contracted providers are experiencing extreme shortages in clinical staff such as psychiatrists, nurses, psychologists, social workers, counselors, behavior analysts, and direct support professionals (DSP). Behavioral difficulties of patients, poor working environments, increased mandatory overtime, and high turnover result in employee injuries and impact quality of care. Public sector salaries fall 30% or more below private health care industry salaries. DSP salaries, compared to those in 21 other states, are 89 cents per hour lower in Missouri. DSPs are paid on average $10.95 per hour. The hourly pay to keep a family of four at the poverty level is $11.00. Key concerns include:

- Missouri ranks the fourth highest in the nation in terms of mental health care professional shortages, with 246 areas facing such shortages, according to the Kaiser Family Foundation. The ranking is based on a quarterly summary of designated Health Professional Shortage Area statistics published September 30, 2020, by the Bureau of Health Workforce and the Health Resources and Services Administration. This designation is given to areas where the population-to-psychiatrist ratio for mental healthcare is at least 30,000 to 1.

- Mental health salary and retirement benefits offered for DMH clinicians are no longer competitive; neither are recruitment and retention benefits, nor college tuition payback strategies.

- Turnover/vacancy rates at DMH facilities are more than double the national and state averages for nurses and other professional staff.

- As of January 2021, the vacancy rate for Psychiatric Technicians is 17% across all hospitals. In our high security hospitals, the vacancy rate for security aides is 10%.

- In December 2020 the average vacancy rate for RNs was 30% and for LPNs the rate was 41%. The vacancy rate for RNs at Fulton State Hospital was 49% and the vacancy rate for LPNs was 57%, despite moving into the new Nixon Forensic Center.

- Overall, 46% of unlicensed psychiatric technician and security aide staff have less than three years of state employment. About 39% of all aides working in a high security environment had less than three years of state employment. These findings suggest that our paraprofessional workforce continues to be inexperienced when working with the state's highest risk psychiatric patients.

- Since 2018, Missouri providers supporting individuals with developmental disabilities have been facing DSP turnover rates in excess of 53% combined with a 6.6% vacancy rate. Turnover and vacancy rates have worsened during the pandemic. On average only 63% of DSPs maintain employment for more than 12 months; survey data covers over 15,000 Missourians employed as a direct support professional.

- The COVID19 pandemic has transformed the work life of the direct care professional into a high risk job complicating recruitment for staff already paid substandard wages. In addition to vacancies due to turnover, providers already stretched to their limits are now faced with vacancies from illness and staff taking off work to manage family responsibilities like helping their children with remote learning when schools are closed or children are under quarantine.

CRITICAL ISSUE: DD Community Provider Rate Corrective Action Plan

Non-standardized rates have been impacting the community providers for many years and the federal government has demanded the State correct this rate inequity. In 2019, the Centers for Medicaid and Medicare Services (CMS) approved a corrective action plan requiring the Division of DD to standardize the residential habilitation rates across all individuals in services and providers. The approved plan allows Missouri to work toward standardized rates over four years (fiscal years 21-24) at a level mutually agreed to by CMS and the State. The rates paid to providers directly affects the wage that can be paid to direct support staff since the majority of the rate goes to direct care staffing and related employee expenses. Below is an overview of rate funding:

- In FY 2014, DD received $23.4 million ($8.9 million GR) to address residential provider rate issues. Funding was targeted to begin standardizing the lowest rates for individuals who have similar service needs. This has allowed the Division to move from a contracted/negotiated rate per provider to a standardized rate for serving adults with developmental disabilities.

- In FY 2017, DD received $80 million ($29 million general revenue) to standardize rates and to fund a 2% inflationary increase for residential, day service, and personal assistance providers. This funding allowed the Division to standardize day service rates,

almost equalize personal assistance rates to that of the Department of Health and Senior Services and move residential rates to 70% of funding needed for rate standardization.

- In FY 2018, DD received $9.8million ($3.5 million general revenue) to standardize DD rates; however, this funding was placed in expenditure restriction, and was core cut in the FY 2019 budget.

- In FY 2019, DD received $2.8 million ($1 million general revenue) to standardize rates, and funding to restore a 1.5% COLA.

- In FY 2020, DD received $58.4 million ($20.1 million general revenue) to standardize rates, and funding for 1.5% COLA for providers excluding residential waiver services. Additional funding provided in the FY 2020 budget allowed the division to raise the lowest rates to 77.7% of the lower bound rate.

- The FY 2021 budget request included an additional $58.1 million. Applied to the lowest rates for each rate allocation score, these additional dollars would have raised the lowest rates to 85.5% of the lower bound rate established through Mercer which has been adjusted for inflation to FY 2020. These dollars were not included in the FY 2021 TAFP budget.

CRITAL ISSUE: Employment

At a time when Missouri is experiencing a statewide workforce shortage, the workforce participation rate for individuals in treatment for serious mental illness (11%), substance use treatment (34%) and intellectual/developmental disabilities (9%) remains considerably lower than that of the general population (61.6%).

DMH is committed to bridging the labor gap and improving the quality of life for the individuals we support. The importance of employment is evidenced by research that has demonstrated its correlation with improved health and decreased health care costs.

Ongoing concerns which suppress greater workforce participation include:

- **Fear of losing benefits:** Similar to tax filing, benefits management and planning is unique to each individual and family. Although there are numerous incentives and contingency programs for maintaining needed benefits while working, one's eligibility is established by the interdependent relationship of their Social Security award, medical coverage, marital status, age, calculated assets and work history.

- **Shortage of and limited access to certified benefit planners:** The Social Security Administration and Medicaid offer several work incentives to assist individuals with asset planning and facilitate transition to the workforce. However, the complexity of decision-making and misinformation perpetuates myths that suppress workforce participation and minimize opportunity for public dollars to maximize a return on investment. An increased number of certified benefits planners would assist individuals with making informed

decisions and remove many of the myths which exists about earned income from employment.

- **Ineffective business engagement:** Effective matching of talent and workforce need is a priority of the individual and employer. Robust relationships between contracted service providers and community business leaders are necessary to accomplish this effective match and to meet the labor shortages of Missouri businesses. Better alignment of the workforce knowledge/skills/abilities to available opportunities is an ongoing challenge.

- **Parallel and competing initiatives:** Numerous state and national efforts require specific assurances tied to the utilization of match dollars. The implementation of these rules and regulations fall upon many different state agencies, regional entities and contracted service providers. Many states have implemented, through legislation or executive order, a unifying commission or board to ensure universal policy design and standardized messaging to families and individuals. Currently, Missourians with disabilities, and their families, are tasked with navigating multiple requirements and conflicting messages from many entities each of which are charged with increasing the employment rate of those with disabilities.

- **Workforce shortage of qualified job support staff:** As noted above, the shortage of qualified direct support professionals exists. Given the unique challenges in the effective delivery of employment support services, the shortage of and frequent turnover of staff results in skillsets which are not adequate to assist with learning national best case practices, effectively evaluate potential job aptitude, implement needed workplace accommodations and support individuals with learning job tasks that result in sustained employment.

- **DD Employment Initiative:** The DD employment initiative, Empowering through Employment, is a statewide effort with a target goal of supporting 35% of all individuals between the ages of 16 to 64 with employment pathways. Since the launch of the initiative, there have been 1,034 individuals pursue employment, an increase of 134%. In addition, 27 private service providers have received training and technical assistance on increasing the quality and effectiveness of employment services and over 1,890 employment support professionals have participated in a monthly community of practice to enhance employment outcomes.

Since 2009, DBH in partnership with Vocational Rehabilitation, has implemented Individualized Placement and Support (IPS), a supported employment, evidence-based practice for individuals with serious mental illness. IPS services are provided in 26 IPS programs (functioning at 31 sites) with six emerging programs. In 2019, 1,200 individuals received IPS with 47% successfully employed. Vocational Specialists serve on nine adult Assertive Community Treatment Teams and 11 Assertive Community Treatment Teams for Transition Aged Youth (TAY). Additionally, Community Support Specialists on Community Psychiatric Rehabilitation teams provide services to support the employment goals of individuals served. In 2020,

Employment Specialists continue to assist individuals with finding employment at ten Improving Community Treatment Success treatment sites and three Recovery Community Centers. For more information visit https://dmh.mo.gov/mental-illness/employment-services.

DMH continues to enhance the systems and service structures in affirming employment rights and opportunities for individuals we serve. A Memorandum of Understanding has been signed by multiple state agencies to collaborate on Employment First for persons with disabilities. For more information visit https://dmh.mo.gov/about/employment-services.

CRITICAL ISSUE: Opioid Crisis

Missouri is impacted heavily by the opioid crisis and the pandemic has exacerbated the loss of life. Deaths associated with opioid overdoses have been rising exponentially, fueled by excessive opioid prescriptions beginning in the 1990s combined with the increased availability of cheap, pure heroin laced with Fentanyl. **Drug poisoning is now the leading cause of accidental death in Missouri**, ahead of motor vehicle crashes, and is the leading cause of death among individuals aged 25-44 years worldwide.

There were 1,094 opioid overdose deaths in 2019 in Missouri, down 3.4% from the previous year. Though slight, this was the first statewide decrease since 2015. Fentanyl continues to be the primary driver of opioid overdose deaths statewide and is more highly concentrated in the eastern region of the state. Specifically, in 2019, approximately 93% of opioid overdose deaths involved fentanyl in the St. Louis region. In 2019, the statewide age-adjusted opioid overdose death rate (per 100,000 people) was approximately 72 among Black males, 20 among White males, 18 among Black females, and 11 among White females. The death rate among Black males was almost four times higher than the statewide average age-adjusted rate of 19. Furthermore, from 2018 to 2019, the overdose death rate increased at a greater rate among Black males relative to any other demographic group (from 57 per 100,000 in 2018 to 72 per 100,000 in 2019). Psychostimulant deaths (excluding cocaine) have been increasing in Missouri, with increases ranging between 23% - 48% per year since 2016. Indeed, in 2019, deaths attributable to psychostimulants had almost doubled since 2017 (451 vs 247, respectively).

Preliminary 2020 data suggest an alarming increase in overdose deaths in Missouri, largely attributable to COVID-19 and the many direct and indirect impacts of the pandemic. DHSS estimates a 33% statewide increase in the first half of 2020 compared to January - June 2019. In St. Louis, though the overall 2020 increase is 54%; the increases among Black males and females are stark – particularly when 2019 was a record-breaking year for Black men. Overdoses increased 64% among Black people in St. Louis this year during COVID-19 but 40% among White people.

Fortunately, the Substance Abuse Mental Health Services Administration (SAMHSA) awarded multiple grants to address the opioid crisis in Missouri. In May 2017, Missouri received a two-year, $20 million SAMHSA grant known as the Opioid State Targeted Response (STR) grant. In October 2018, additional funding arrived via a two-year, $36 million SAMHSA grant known as the State Opioid Response (SOR). Missouri's SOR project built upon the system changes for

opioid use disorder (OUD) prevention, treatment, and recovery implemented through Missouri's STR grant. In FY21 Missouri received another SAMHSA State Opioid Response 2.0 (SOR 2.0) grant for $25,017,670 a year, or $50 million total for a two-year period. These newer funds enhance the system changes for OUD prevention, treatment, and recovery implemented through Missouri's STR/SOR grants while expanding focus on minority populations, stimulant use disorder, telehealth services, and peer specialists. The SOR 2.0 grant began September 30, 2020, and ends September 29, 2022. DMH leads the project in collaboration with the University of Missouri, St. Louis (UMSL) – Missouri Institute of Mental Health. For more information, visit these links: this: https://www.nomodeaths.org/ and https://dmh.mo.gov/opioid-crisis-response.

CRITICAL ISSUE: Provider Rate Inequities

Community-based services contracts comprise 80% of the Department's total budget yet serve more than 95% of DMH consumers. The provider reimbursement rates have lagged behind inflation due to the state's failure or inability to adjust them each year. Providers struggle to meet costs for food, fuel, insurance, and proper staffing. A 1.5% core reduction and an additional 1.5% expenditure restriction eliminated the COLAs appropriated in FY 2016 and FY 2017. In the FY 2018 budget, a 1.5% COLA was restored but placed into expenditure restriction. In FY19, a 1.5% increase was restored, as well as an additional 1.5% in FY20.

- Like the state-operated facilities, the community-based treatment agencies face daunting challenges in recruitment and retention of qualified staff in clinical and direct care positions. Like the state facilities, it is difficult for community providers to compete with the US Department of Veterans Affairs and private health care organizations for psychiatrists, registered and licensed professional nurses, and licensed behavioral health professionals (social workers, counselors, etc.). Even in years where annual inflationary adjustments have been made, the costs of medication for the uninsured, food for residential programs, transportation to aid in access, and technology (electronic medical records, telehealth equipment, etc.) far exceeded the inflationary adjustments. Often times these community agencies and state facilities unsuccessfully compete with fast food chains and big box retail stores for employees to serve as direct care staff. Agencies who have converted to a cost-based reimbursement methodology, like the CCBHOs, have been better able to recruit and retain staff, which is key to better clinical services, as well as financial stability in difficult economic times, such as the current pandemic.

CRITICAL ISSUE: State Inpatient Facility Capacity

Division of Behavioral Health inpatient hospitals are continuously at absolute capacity and must schedule admissions for individuals committed by the criminal courts who have been found incompetent to stand trial. DBH has begun using alternative options for individuals with behavioral health conditions who become involved in the criminal justice system such as outpatient competency restoration and a mobile team of mental health professionals who provide medication consultation and supports for individuals in jails.

CRITICAL ISSUE: Uninsured Individuals Seeking Services

It is very difficult for many Missourians to access behavioral health services, and it is particularly hard for those without insurance. Medicaid Expansion, passed in August 2020, will help extend access to behavioral health services for many Missourians, but DMH continues to serve as the public safety net for individuals who lack insurance for any number of reasons. This makes the continued support of General Revenue, which also assures receipt of federal block grant funds, essential.

- Budget reductions in recent years have dramatically reduced the state funding available for uninsured individuals, resulting in DMH serving mostly people who are covered under Medicaid. While this stretches state dollars, it dramatically limits services for people who do not have health insurance or who have exhausted their insurance benefits. Many people who have substance use disorders or are in the early stages of serious mental illness often do not qualify for Medicaid:
  - Some college students experiencing serious mental illness like schizophrenia, bipolar disorder, or major depression do not have health insurance and are not Medicaid eligible.
  - Of the people leaving the Department of Corrections (DOC), 83% have histories of moderate to severe substance use disorders, 19% have serious mental illnesses, and most are not Medicaid eligible; yet their conditions of parole often require that they obtain behavioral health treatment.
  - Of all individuals seeking treatment for substance use disorders through department funded providers in FY19, 60% had no insurance. For those seeking treatment for serious mental illness, 20% did not have insurance.
- Without appropriate access to services, many people experiencing a behavioral health crisis seek help at emergency rooms, get in trouble with the law, become dangerous to themselves or others, become homeless and/or experience repeated hospitalizations.
- If treatment and recovery supports are not accessible through DMH, then hospitals, jails, DOC, police departments, homeless shelters, and physicians provide patchwork services that often are inappropriate, expensive, and leave the individual without necessary follow-up care, creating a dangerous and costly cycle.

V. Partners in Public Service: Constituent Issues

As an elected official, you may receive inquiries regarding DMH services from your constituents. All constituent needs and concerns are a priority for us. Here is our process for addressing constituent issues plus tips on information your office can provide to expedite the process.

What we need:

- As much detailed information as feasible, preferable by email.
  - Name, address, phone number, email of constituent.
  - Consumer full name, along with age or birthdate.
  - Services the person is receiving or seeking.
  - Concrete concerns about a provider or program.
  - Any deadline or timeframe they are addressing.
- Ask what they specifically want/need from you and from DMH. Sometimes constituents just want to vent to you about a personal situation which cannot be addressed by public servants.
- If they are difficult or upset, connect them with the Access/Crisis Intervention (ACI) line (see link below under Resources).

What we do with the information you provide:

- Check our system and appropriately follow-up with existing consumers:
  - Wellness check.
  - Investigate complaints or concerns.
  - Provide families/concerned citizens with educational information and resources on programs and services available through DMH.
- Collaborate with other agencies and partners.
  - Many constituents receive services from multiple agencies: DMH, DSS, and DHSS frequently share/refer/problem solve.

Restrictions:

- Health Insurance Portability and Accountability Act (HIPAA)—without permission from the person under care, we cannot discuss mental health records with anyone who is not authorized to review that information.
- DMH has no authority or influence with programs/services/providers that do not contract with us such as those who only accept private insurance.
- DMH cannot referee family disputes or issues with the public administrator but there are resources that can address such issues.

Resources:

- DMH ACI Line—listing by county of toll-free connection to a mental health professional 24/7.

- Legal Aid—for constituents who cannot afford an attorney.
- Protection and Advocacy—for constituents who have complaints against state agencies and need an advocate.

HELP US COMBAT STIGMA

Harmful words are the driving force behind stigma. Words and phrases can impact how someone lives their life by making them feel not "good enough" or "less than" others. Follow these links to our website for words to use and avoid in conversation.

Join us in following the guidance of People First Language.

Rule 1. Call the person by their name.
Rule 2. If you speak with someone living with a health or mental health disability, remember to speak to the person first and then the disability second. Here are some examples:

Say:	Instead of:
People with disabilities	The handicapped or disabled
Bob's son has autism	Bob's autistic son
Susan's daughter has Down Syndrome	Susan's Down syndrome daughter
Brain injury	Brain damaged
Accessible parking, hotel room, etc.	Handicapped parking, hotel room, etc.
Deb uses a wheelchair/mobility chair	Deb is confined to a wheelchair or is wheelchair bound
Jim has bipolar disorder	Jim is bipolar
Mark has a substance use disorder	Mark is an alcoholic (or druggie, pothead, substance abuser, etc.)

Other resources:

Behavioral Health and Developmental Disability Language

Substance Use Disorder Language

Thank you for being our partner in public service and choosing respectful language to assist our mission to reduce stigma.

AMBASSADORS ACADEMY

To learn more about the Department and how we can assist your constituents, review our Ambassadors Academy sessions held Fall 2014-2019 at the Capitol. DMH leaders and partners shared behavioral health and developmental disabilities updates and program innovations that are making a difference for Missouri's most vulnerable citizens. We are transitioning to a virtual program for 2021 as the 2020 Ambassadors Academy was not held due to the pandemic.

VI. DMH Contact Information

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